VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

INSTRUCTIONS: Complete this form on the initial home visit for all BabyCare recipients. *Items in italics apply to pregnant women only*. **Items in bold type apply only to infants.** Items in normal type apply to both women and infants.. **See explanation of codes on reverse of form.

1. Last Name _____ 2. First Name _____ 3. MI _____
For Infant, name of mother/guardian _____
4. Street Address _____ 5. City _____ 6. State_____ 7. Zip _____
8. Recipient's Medicaid ID # __ __ __ __ __ __ __ __ __ __ __ __ 9. Birthdate __ __ - __ __ - __ __ __ __

**10. Occupation (circle one) 0 1 2 9 **11. Marital Status (circle one) 0 1 9 **12. Education Level (circle one) 0 1 2 9
13. # of Live Births __ __ *14. Abortions* __ __ *15. Miscarriages* __ __ *16. Stillbirths* __ __
17. EDC __ __ - __ __ - __ __ __ __ *18. Weeks of gestation when prenatal care began* __ __

19. Provider Name _____ 20. Provider # __ __ __ __ __ __ __ __ __ __ __ __ 21.Visit Date __ __ - __ __ - __ __ __ __

Psychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home	___	____	28. Insufficient funds for food	___	____	**34. Caregiver handicap**	___	___
23. Poor support system	___	____	29. Transportation need	___	____	**35. Maternal absence**	___	___
24. Poorly motivated	___	____	30. Neglect/Abuse	___	____	**36. Protective services**	___	___
25. Religious/ethnic factors affecting pregnancy	___	____	31. Childcare needs/poor parenting knowledge/pregnancy info	___	____	**37. Poor emotional bonding**	___	___
26. Housing needs	___	____	32. Multiple medical providers	___	____			
27. Family has urgent health needs	___	____	33. Mental retardation/ emotional problems	___	____			

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation	___	___	42. Genetic Disorder	___	___	**45. Infant chronic illness**	___	___
39. Prior preterm <5 1/2 lb.	___	___	43. Previous fetal/infant death or infant morbidity	___	___	**46. Developmental delay**	___	___
40. Advanced maternal age >35	___	___				**47. Infant apnea**	___	___
41. Medical condition affecting pregnancy/infant	___	___	44. Previous poor pregnancy experience - medical	___	___	**48. Birth weight < 3 lbs 14 oz**	___	___

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt.	___	___	54. Poor basic diet info	___	___	59. Anemia	___	___
50. Prepregnancy underwgt.	___	___	55. Special diet/formula prescribed	___	___	**60. Inadequate sucking**	___	___
51. Excessive Nausea/Vomiting	___	___	56. Medical ondition affects diet	___	___	**61. Breast feeding problems**	___	___
52. Excessive wgt. gain	___	___	57. Inadequate cooking facility	___	___	**62. Poor use of special formula**	___	___
53. Inadequate wgt. gain	___	___	58. Mother age 18 or younger	___	___			

Substance Abuse Usage At Current Time

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
63. Alcohol	____	____	*66. Marijuana/hashish*	____	____	*69. Inhalants*	____	____
64. Cocaine/crack	____	____	*67. Sedatives/tranquilizers*	____	____	*70. Tobacco/cig.*	____	____
65. Narcotics/heroin/codeine	____	____	*68. Amphetamines/diet pill*	____	____	*71. Other*	____	____

Substance Abuse Usage Prior To Start Of Pregnancy

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
72. Alcohol	____	____	*75. Marijuana/hashish*	____	____	*78. Inhalants*	____	____
73. Cocaine/crack	____	____	*76. Sedatives/tranquilizer*	____	____	*79. Tobacco/cig.*	____	____
74. Narcotics/heroin codeine	____	____	*77. Amphetamines/diet pill*	____	____	*80. Other*	____	____

81. Significant Findings

82. COORDINATOR'S SIGNATURE _____ 83. DATE __ __ - __ __ - __ __ __ __

DMAS-50 rev. 3/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

Instructions for Completing DMAS-50 Form

1. Enter Recipient's Last Name. **Required.**
2. Enter Recipient's First Name. **Required.**
3. Enter Recipient's Middle Initial. **Required.**
4. - 7. Enter Recipient's Address. **Required.**
8. Enter Recipient's Medicaid ID Number. (NOTE: Enter the infant's number, not mother's, if recipient is an infant.) **Required.**
9. Enter the Birthdate of the Recipient in MM-DD-CCYY format. **Required.**
10. Circle the appropriate code for the Recipient's Occupation: **Required.**
    - 0 None (Attends school)
    - 1 Not heavy work (Any work outside the home, or in the home for pay, full time or part time, not included under heavy work.)
    - 2 Heavy work (Any work involving strenuous physical effort)
    - 9 Unknown
11. Circle the appropriate code for the Recipient's Marital Status: **Required.**
    - 0 Married
    - 1 Unmarried (single, separated or divorced)
    - 9 Unknown
12. Circle the highest Education Level reached by the Recipient: **Required.**
    - 0 High School graduate or higher
    - 1 9th to 12th grade
    - 2 8th grade or less
    - 9 Unknown

13. Enter the number of Live Births the mother has had.

14. Enter the number of Abortions the mother has had.

15. Enter the number of Miscarriages the mother has had.

16. Enter the number of Stillbirths the mother has had.

17. Enter the Estimated Date of Confinement (EDC) in MM-DD-CCYY format. **Required.**

18. Enter the number of Weeks gestation at which prenatal care began. **Required.**

19. Enter the Provider Name. **Required.**
20. Enter the Provider's Medicaid ID Number. **Required.**
21. Enter the date of the home visit in MM-DD-CCYY format. **Required.**

22. - 62. Assessments
Check "YES" if the indicated problem is a risk for the recipient. Check "NO" if it is not. (NOTE: Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** type apply only to infants.)

63. - 80. Substance Abuse Usage
Enter the **number** of days per week and the **number** of times per day the recipient uses or used each substance. If the recipient does not use the substance, leave the lines blank. If an entry is made in field 71 (Other), the name of the substance/drug must be listed.

81. Enter any Significant Findings discovered during the assessment.
82. Coordinator's Signature. The BabyCare Coordinator must sign the form. **Required.**
83. Date. The BabyCare Coordinator must date the form. **Required.**

For more complete information on BabyCare policy and procedures, please refer to the BabyCare Provider Manual.